

Research Update is published by the Butler Center for Research to share significant scientific findings from the field of addiction treatment research.

## Health Care Professionals: Addiction and Treatment

Health Care professionals (HCPs) are widely considered to be the champions of healthy habits and, on the whole, demonstrate healthier lifestyles than the general population, including lower rates of smoking and higher rates of exercise.<sup>1</sup> However, substance misuse and addiction rates are no different among HCPs than they are in the general population, and HCPs demonstrate significantly higher levels of opioid abuse.<sup>1,2</sup> These problems are particularly troubling in a provider population, as they can lead to serious safety issues for the patients HCPs treat while under the influence.

### Patterns of Addiction and Substance Abuse Among HCPs

While the American Medical Association did not develop a formal policy to address HCP impairment related to drugs and alcohol until the 1970s, the problem has existed in scientific literature since 1869, referred to back then as “habits of intemperance.”<sup>1</sup> In fact, ether was first used in surgery as an anesthetic in 1842 by a surgeon who was familiar with the substance through his recreational use of it at “ether frolics.”<sup>3</sup> Since then, prescription drug abuse and addiction among HCPs has continued to grow significantly—especially for anesthetic and analgesic (painkiller) agents.<sup>1,2,3,5</sup> Studies in the United States have shown that 10%–15% percent of HCPs will misuse substances during their lifetime,<sup>2,4,5</sup> and rates of prescription drug abuse and addiction are 5 times higher among physicians than in the general population, with especially high rates of benzodiazepine and opioid abuse.<sup>1,5,6,7</sup> Physicians are not the only HCPs affected by drug and alcohol abuse: A 2010 investigation into the Texas Board of Nursing found that approximately one third of all disciplinary actions taken against nurses were drug or alcohol related (see figure).<sup>8</sup>



Image Source: The Texas Tribune, 2010

No single reason has been identified to explain why the rate of opioid misuse among HCPs is so much higher than in the general population, but several promising theories have been presented. One such theory suggests that increased access to prescription drugs contributes to higher rates of misuse and dependence. Studies of self-prescribing behaviors have uncovered that 87% of physicians have prescribed themselves medications,<sup>1,2,9</sup> and over half (55.3%) of HCPs who have a prescription for painkillers wrote the prescription themselves.<sup>1,7</sup> Research has also found that many HCPs report that they began abusing prescription drugs after receiving their prescribing privileges.<sup>10</sup> Other theorists believe that high work-related stress; exposure to illness, death, and trauma; extreme work responsibilities; and sleep deprivation are what lead HCPs to misuse drugs and alcohol as a maladaptive coping strategy.<sup>11,12,13</sup> However, this theory has mixed support from self-report studies that indicate that some HCPs do not report

### THE HAZELDEN BETTY FORD EXPERIENCE

The Hazelden Betty Ford Foundation offers comprehensive addiction treatment programs designed specifically for HCPs, including a first-of-its-kind specialized program for nurses. These programs follow evidence-based best practices for addressing the unique problems faced by HCPs as patients and recovering addicts and have been highlighted in the scientific literature for their effectiveness.<sup>1</sup> The programs also offer help with issues related to professional licensure, employment, and medical reputation.

### QUESTIONS AND CONTROVERSIES

*Why are specialized programs necessary for HCPs?*

HCPs have a variety of unique risk factors, including higher access to prescription drugs, high levels of workplace stress, and sleep deprivation that make them very susceptible to substance abuse and relapse. State boards also require more intensive treatment because HCP drug use is considered a health and safety risk to the patients substance-abusing HCPs treat. Specialized treatment programs provide these more intensive interventions to ensure that HCPs are able to safely return to practice without relapse.

*If I am an HCP and seek help, won't I lose my medical license?*

No. Many state PHPs allow HCPs to return to work after treatment and a “fitness-for-duty” assessment. They also offer resources for concerns related to licensure, employment, medical reputation, and finding HCP-specific Twelve Step support following treatment. Five years after successfully completing their primary treatment via PHPs, 95% of HCPs are licensed and employed in the health care field.<sup>19</sup>

### HOW TO USE THIS INFORMATION

**Health Care Providers:** Addiction is a disease just like any other that requires treatment in order to improve. While the fear of social and professional ramifications can be daunting, the PHPs in many states allow physicians and other HCPs to voluntarily enter treatment programs while remaining anonymous and facilitate a successful return to practice after treatment is completed. Contact your state's PHP at [fsphp.org](http://fsphp.org) for information on how you can get treated and return to work.

**Family Members and Colleagues:** Identifying substance abuse behaviors among HCPs can be difficult, and fear of negative consequences can make them hesitant to admit that they have a problem. State PHPs have been designed to minimize negative consequences that HCPs may face by helping them get the treatment they need. If you suspect that your loved one or colleague is exhibiting substance abuse or addiction behaviors, contact your state's local PHP to have them facilitate an intervention.

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using drugs or alcohol as self-medication for stress,<sup>14</sup> while others do indicate that they use drugs and alcohol to manage emotional and psychiatric distress and stressful situations.<sup>15</sup> It is generally accepted that these, and other theories, explain the heightened potential for abuse and addiction among providers who already demonstrate other key risk factors (such as genetic predisposition, previous experimentation with controlled substances, comorbid psychiatric diagnoses, or early first use of alcohol or tobacco).<sup>1,10</sup>

## Treating HCPs for Addiction and Substance Abuse

Although every state currently has its own impaired physician program as a means of increasing patient safety, HCPs are still undervalued and undertreated for addiction and substance abuse.<sup>1</sup> This is largely due to the hesitancy of HCPs, as well as their colleagues and family members, to report any problems with substance abuse or addiction for fear of potentially negative social, professional, legal, or financial consequences.<sup>1,2,16</sup> Ironically, another major barrier to treatment is the pattern of personality traits common among HCPs that contributes to their professional success (e.g., independence, perseverance, self-reliance), as these traits make many HCPs resistant to ask for help.<sup>17</sup> It is recommended that anyone who is hoping to refer an HCP for treatment first contact their state's Physician Health Program (PHP), as these agencies have the expertise and resources to effectively facilitate an intervention and assist HCPs in leveraging available programs. PHPs will also often allow HCPs to enter treatment anonymously, given that they voluntarily participate in the treatment program. In these cases, the PHP will confidentially assist HCPs in finding clinical coverage for their treatment duration.<sup>1</sup>

HCP-specific treatment programs are critical, as state medical boards require higher levels of treatment intervention in the interest of patient safety.<sup>2</sup> HCPs who use opioids also demonstrate significantly higher risk of relapse than the general population,<sup>18</sup> requiring more intensive post-treatment monitoring and continuing care recovery plans. Specialized programs for HCPs not only provide more intensive treatment and continuing care plans but also work with patients in matters specific to professional licensing, private practice, medical reputations, and other unique areas of interest.<sup>19</sup> To avoid any risk of bias during treatment, it is strongly recommended that HCPs are treated outside of their medical community by counselors and doctors with whom they are relatively unfamiliar.<sup>1</sup>

While HCPs may be subject to unique risks for substance misuse and relapse, they demonstrate some of the highest success rates in any specialized population. A 2008 longitudinal study reported that 81% of the participants who completed their treatment programs maintained sobriety for five years posttreatment.<sup>20</sup> There does not appear to be a significant difference in outcomes for those who self-refer to treatment and those who are coerced by the Board of Medicine, as the threat of losing their licenses was thought to be an effective catalyst for nonvoluntary HCPs to attend treatment and follow their continuing care plans.<sup>1</sup> Monitoring HCPs with random drug tests after treatment has proven to be very effective in maintaining high abstinence rates. One study found that 96% of HCPs who were subject to random drug tests remained drug free, compared to only 64% of HCPs who were not subject to mandatory testing.<sup>21</sup> Of those HCPs who completed their treatment requirements, 95% were licensed and actively working in the health care field at a five year follow-up after completing their primary treatment program.<sup>19</sup>

## Summary

HCPs struggling with substance abuse and addiction face significant consequences if they remain untreated, not only for themselves but also for the patients they treat. The implications for patient safety require HCPs to receive more intensive treatment than the general population, but specialized HCP treatment programs meet these stricter requirements, while also helping HCPs maintain (or regain) their medical licenses and reduce the potential for negative professional and social consequences related to seeking help.

## References

- Merlo, L., & Gold, M. (2008). Prescription opioid abuse and dependence among physicians: Hypotheses and treatment. *Harvard Review of Psychiatry*, 16(3), 181–94.
- Bennett, J., & O'Donovan, D. (2001). Substance misuse by doctors, nurses, and other healthcare workers. *Current Opinion in Psychiatry*, 14, 195–199.
- Hammonds, W. D., & Steinhilber, J. E. (1993). Crawford W. Long: Pioneer physician in anesthesia. *Journal of Clinical Anesthesia*, 5, 163–167.
- Baldisseri, M. R. (2007). Impaired healthcare professional. *Critical Care Medicine*, 35, S106–S116.
- Merlo, L. J., Trejo-Lopez, J., Conwell, T., & Rivenbark, J. (2013). Patterns of substance abuse initiation among healthcare professionals in recovery. *The American Journal on Addictions*, 22, 605–612.
- Hughes, P. H., Storr, C. L., Brandenburg, N., Baldwin, D. C., Anthony, J. C., & Sheehan, D. V. (1999). Physician substance abuse by medical specialty. *Journal of Addictive Diseases*, 18(3), 23–37.
- Hughes, P. H., Brandenburg, N., Baldwin, D. C., Storr, C. L., Williams, K. M., Anthony, J. C., & Sheehan, D. V. (1992). Prevalence of substance use among U.S. physicians. *JAMA*, 267(17), 2333–2339.
- Ramshaw, E. (2010, March 17). Texas nurses battle drug addictions. *The Texas Tribune*, pp. A1, A4.
- Christie, J., Rosen, I., Bellini, L., Inglesby, T. V., Lindsay, J., Alper, A., & Asch, D. A. (1998). Prescription drug use and self-prescription among resident physicians. *JAMA*, 280(14), 1253–1255.
- Hughes, P. H., Conrad, S. E., & Baldwin, D. C. (1991). Resident physician substance abuse in the United States. *JAMA*, 265, 2069–2073.
- Richman, J. A. (1992). Occupational stress, psychological vulnerability, and alcohol-related problems over time in future physicians. *Alcohol Clinical Experimental Research*, 16, 166–171.
- Kenna, G. A., & Lewis, D. C. (2008). Risk factors for alcohol and other drug use by healthcare professionals. *Substance Abuse Treatment, Prevention, and Policy*, 3, 3–11.
- Berge, K. H., Seppala, M. D., & Schipper, A. M. (2009). Chemical dependency and the physician. *Mayo Clinic Proceedings*, 84(7), 625–631.
- Jex, S. M., Hughes, P. H., Storr, C. L., Conrad, S., Baldwin, D. C., & Sheehan, D. V. (1992). Relations among stressors, strains, and substance use among resident physicians. *International Journal of the Addictions*, 27(8), 979–994.
- Merlo, L. J., Singhakant, S., Cummings, S. M., & Cottler, L. B. (2013). Reasons for misuse of prescription medication among physicians undergoing monitoring by a physician health program. *Journal of Addictive Diseases*, 7(5), 349–353.
- Brooke, D. (2000). Doctors and their health: Drug and alcohol problems. In Ghodse, H., Johnson, P., Mann, S. (Eds.) *Doctors and their health*. London: St. George's Medical School Centre for Addiction Studies.
- Biosaubin, E. V., & Levine, R. E. (2001). Identifying and assisting the impaired physician. *American Journal of the Medical Sciences*, 322, 31–36.
- Domino, K. B., Hornbein, T. F., Polissar, N. L., Renner, G., Johnson, J., Alberti, S., & Hanks, L. (2005). Risk factors for relapse in health care professionals with substance use disorders. *JAMA*, 293(12), 1453–1460.
- DuPont, R. L., McLellan, A. T., Carr, G., Gendel, M., & Skipper, G. E. (2009). How are addicted physicians treated? A national survey of physician health programs. *Journal of Substance Abuse Treatment*, 37, 1–7.
- McLellan, A. T., Skipper, G. S., Campbell, M., & DuPont, R. L. (2008). Five year outcomes in a cohort study of physicians treated for substance use disorders in the United States. *BMJ*, 337, 2038–2044.
- Shore, J. (1987). The Oregon experience with impaired physicians on probation: An eight year follow-up. *JAMA*, 257, 2931–2934.

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